Patient Authorization

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information:**

* All information provided herein is true and correct
* I hereby give consent to treatment
* I give permission to Faith Pediatric Rehabilitation to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare professional, assignees and/or beneficiaries and all other related persons as it relates to my or my child’s treatment.
* I authorize Faith Pediatric Rehabilitation to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.
* Information without patient identifiers may be used for quality assurance purposes.
* I have read and understand the above release

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Guardian Signature DATE**

**Assignment of Benefits**

* I authorize payment directly to Faith Pediatric Rehabilitation, its subsidiaries and/or affiliates for services
* This is a direct assignment of my rights and benefits under this policy
* A photocopy of this assignment shall be considered as effective and valid as the original

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature DATE

Payment Guarantee

* I agree to pay Faith Pediatric Rehabilitation, its subsidiaries and/or affiliates for the services provided to me or the party named above. F any insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any oher type of information necessary to allow for the speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.
* The benefit Verification form is only a explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.
* I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Faith Pediatric Rehabilitation and/or its affiliates or subsidiaries.

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_